STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155148	A. BUILDING 00 B. WING	02/28/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTH PARK NURSING CENTER	650 FAIRWAY DR EVANSVILLE, IN 47710

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	This visit was for Investigation of Complaints IN00103856 and IN00104314. Complaint IN00103856 - Substantiated. Federal/state deficiencies related to the allegations are cited at F253, F312, F314, F315, F465 and F514. Complaint IN00104314 - Substantiated. Federal/state deficiencies related to the allegations are cited at F314 and F514. Unrelated deficiencies cited. Survey dates: February 26, 27, and 28, 2012 Facility number: 000069 Provider number: 155148 AIM number: 100288980 Survey team: Jennie Bartelt, RN Census bed type: SNF: 9 SNF/NF: 83 Total: 92 Census payor type: Medicare: 13 Medicaid: 70	F0000	The creation and submission of this Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. This provider respectfully requests that the 2567L Plan of Correction be considered the Letter of Credible Allegation and requests a Desk Review in lieu of an on-site visit on or after March 16, 2012.North Park Nursing and Rehabilitation Center650 Fairway DriveEvansville, Indiana 47710Telephone: 812-425-5243Respectfully, Kathleen BodeckerExecutive Director	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	Other: 9 Total: 92 Sample: 4 These deficiencies reflect state findings cited in accordance with 410 IAC 16.2. Quality review completed 3/2/12 Cathy Emswiller RN			

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F0253 SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. Based on observation, record review, and interview, the facility failed to ensure the shower rooms were clean and had functioning lights, and failed to ensure hallways were clean and in good repair for 2 of 4 hallways in the facility. (Faith Meadows and Melody Lane) The deficient practice affected 49 of 92 residents residing in the facility. Findings include: On 2/26/12 the following was observed: During Initial Tour at 3:30 p.m.: 1. The vinyl tile flooring on the Melody Lane unit hallway, outside Rooms 127 and 128, was crazed, cracked, and scuffed. A crack in the floor, with concrete visible underneath, ran from the Melody Lane unit hallway into Room 125 over to the room's window. 2. The floor of the linen closet next to Room 125 on Melody Lane was soiled with gray stains. Linens including sheets, towels, and washcloths were stored in the closet.	F0253	The creation and submission of this Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. This provider respectfully requests that the 2567L Plan of Correction be considered the Letter of Credible Allegation and requests a Desk Review in lieu of an on-site visit on or after March 16, 2012. F**253 Housekeeping & Maintenance Services.** This facility provides housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** · No residents were identified in the alleged deficient practice. · Residents who reside at the facility have the potential to be affected by the alleged deficient practice. · Approval has been received	03/16/2012

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	3. At 6:55 p.m., the shower room on Faith Meadows Hall had a black substance on the grout in both corners of the middle shower stall and the right corner of the shower stall to the left. 4. At 7:05 p.m., in the shower room on Melody Hall the overhead lights were not functioning in the left and right shower stalls. During interview at this time, CNA #9 indicated the switch plate next to the door controlled all the lights and was on. The switch plate for the lights had black dirt in its crevices. 5. At 7:15 p.m., in the shower room across from the Nurse's Station for the Melody Lane, the overhead lights were not functioning in the left and right shower stalls. During interview at this time, the Director of Nursing Services (DNS) indicated most residents used the middle stall anyway. The DNS indicated Maintenance would need to change the lights. 6. The doors to the three shower rooms were observed to be gouged and marred. 7. At 7:20 p.m., LPN #17 was observed passing medications on Melody Hall. A small chain was observed hanging from the bottom of the medication cart onto the		to proceed with replacement of flooring to be completed by 05-01-12. · The floor of the linen closed next to Room 125 has been cleaned. · New shower room doors for all showers were ordered on 03/15/12. · All shower rooms have been deep cleaned to include tile and switch plate on 03/08/12 by Housekeeping on 03/08/12 by Supervisor/Designee. · An audit was completed of the overhead lights to ensure all lights were functioning completed on 03/08/12 by Maintenance Supervisor/Designee. · The medication carts were cleaned and placed on a routine cleaning schedule on 03/08/12 by DNS/Designee. · Chains hanging under medication carts have been removed by Maintenance Supervisor/Designee. **How would you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** · Residents who reside at the facility have the potential to be affected by the alleged deficient practice. · Approval has been received to proceed with replacement of flooring to be completed by 05-01-12. · The floor of the linen closed	

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	floor, and a dust ball about three to four inches wide was clinging to the chain and dragging along the hallway. LPN #17 asked what was being observed, and she used a sanitizing wipe to remove the dust ball. During interview on 2/28/12 at 11:55 a.m., the DNS provided paperwork she indicated was related to the facility's flooring. During interview at this same time, the Administrator indicated the replacement of the cracked, crazed, and scuffed floors had been approved to happen this year. Review of the paperwork provided indicated, "Health and Hospital Corporation 2012 Capital Budget Request North Park Nursing Center." No signatures on the documentation indicated approval or dates of approval of the installation of new flooring. During Initial Tour on 2/26/12 at 3:30 p.m., the Assistant Director of Nursing provided a list of residents in the facility. Review of the list indicated 23 residents lived on Melody Lane and 26 residents lived on Faith Meadows. This federal tag relates to Complaint IN00103856. 3.1-19(f)		next to Room 125 has been cleaned. · All shower room doors have been ordered on 03/15/12. · All shower rooms have been deep cleaned to include tile and switch plate on 03/08/12 by Housekeeping on 03/08/12 by Supervisor/Designee. · An audit was completed of the overhead lights to ensure all lights were functioning completed on 03/08/12 by Maintenance Supervisor/Designee. · The medication carts were cleaned and placed on a routine cleaning schedule on 03/08/12 by DNS/Designee. · Chains hanging under medication carts have been removed by Maintenance Supervisor/Designee. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** · Housekeepers were re-educated on appropriate cleaning technique of shower rooms, switch plates, resident rooms, and hall ways by the Housekeeping Supervisor on 3-8-2012. · Licensed nurse and aides were re-educated on cleanliness of environment/medication carts by the DNS/Nurse Consultant/Designee on 3-8-2012. · Housekeeping	

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			Supervisor/Nurse managers will round daily to ensure all rooms/showers are cleaned according to procedure. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** · A Quality Control Inspection checklist will be completed for compliance weekly x 4, and monthly times 3, quarterly thereafter until compliance x2. Data collected will be review by the CQI Committee. If threshold of 95% is not achieved, an action plan will be written. **What is the date by which the systemic changes will be completed?** March 16, 2012	

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F0282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. Based on record review and interview, the facility failed to ensure the resident's medication was administered as ordered by the physician for 1 of 3 residents reviewed related to physician's orders in a sample of 4 (Resident D) Findings include: Resident D was identified as interviewable on a list provided by the Assistant Director of Nursing at the time of the Initial Tour on 2/26/12 at 3:30 p.m. During interview completed on 2/28/12 at 11:15 a.m., Resident D indicated he did not always receive the suppository ordered for assistance with bowel evacuation every other day. The clinical record for Resident D was reviewed on 2/26/12 at 7:25 p.m. The record indicated the resident was readmitted to the facility on 1/31/12 after being hospitalized on 1/28/12. Diagnoses included, but were not limited to, quadriplegia.	F0282	**F282 Services by Qualified Persons/Per Care Plan** This facility provides or arranges services that are provided by qualified persons in accordance with each resident's written plan of care. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** · Resident D receives his medication as ordered by the Physician. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** · Residents who receive medication have the potential to be affected by the alleged deficient practice. · Licensed Nurse were re-educated on following the physician's orders as written and documenting medication administration on the medication record by the DNS/designee on 3-8-2012. · Audit was completed for all residents who receive suppositories to ensure no other issues were identified. **What measures will be put into place or what systemic changes you**	03/16/2012

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	Physician's orders on the February 2012 recapitulation orders indicated an order, originally dated 2/22/10, for "Bivasc-evac 10 mg sup [suppository], insert 1 suppository rectally every other day." The Routine Medications record for February 2012 indicated the resident's medication was not administered as scheduled on 2/16/12 at 8:00 p.m.. The space for the nurse's initials to indicate administration was blank, and no information related to the omission was indicated. 3.1-35(g)(2)		**will make to ensure that the deficient practice does not recur?** · Licensed Nurses will audit medication/treatment records with on-coming shift to ensure medications are dispensed as prescribed and documentation is complete. · Nurse Manager's will audit medication/treatment records weekly x 4 then monthly x 3 on 100% of residents to ensure compliance. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** · A Medication Audit will be conducted weekly x 4 times then monthly x 3 then quarterly thereafter until compliance x2 by DNS/Designee. · Data collected will reviewed by the CQI Committee. Those found to be non-compliant will receive re-education up to disciplinary action. If threshold of 95% is not achieved an action plan will be written. **What is the date by which the systemic changes will be completed?** March 16, 2012	

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F0309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Based on record review and interview, the facility failed to ensure staff followed the resident's bowel management program, including administration of a laxative suppository, as ordered by the physician for 1 of 1 resident reviewed related to bowel management in a sample of 4 (Resident D) Findings include: Resident D was identified as interviewable on a list provided by the Assistant Director of Nursing on Initial Tour on 2/26/12 at 3:30 p.m. During interview completed on 2/28/12 at 11:15 a.m., Resident D indicated a problem with care he encountered was related to his bowel regimen. Resident D indicated he was supposed to receive a suppository to assist with bowel movements every other day - Monday, Wednesday, Friday, then Sunday, Tuesday, Thursday, Saturday. Resident D indicated some nurses always gave the	F0309	**F309Services by Qualified Persons/Per Care Plan** This facility provides or arranges services that are provided by qualified persons in accordance with each resident's written plan of care. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** · Resident D receives his medication as ordered by the Physician. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** · Residents who receive medication have the potential to be affected by the alleged deficient practice. · Licensed Nurse were re-educated on following the physician's orders as written and documenting medication administration on the medication record by the DNS/designee on 3-8-2012. · Audit was completed for all residents who receive suppositories to ensure no other	03/16/2012

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	suppository correctly, and others didn't. Resident D indicated the record always showed the nurses gave the suppository, even when he knew they did not do so. Resident D indicated he requests the suppository at 9:00 p.m., but sometimes the nurse gives it at 10:30 p.m., and then he falls asleep before it is effective. Resident D indicated the suppository usually worked within about 15 minutes. Resident D indicated he had been in the hospital in the past for problems with his bowel, because he was constipated. In a subsequent interview on 2/28/12 at 5:20 p.m., the resident indicated he was sure he would receive the suppository today, because the nurse who was working gives the medication. He indicated the doctor in the past had told him he could die if his bowels did not move regularly. The clinical record for Resident D was reviewed on 2/26/12 at 7:25 p.m. The record indicated the resident was readmitted to the facility on 1/31/12 after being hospitalized on 1/28/12. Diagnoses included, but were not limited to, quadriplegia. Physician's orders on the February 2012 recapitulation orders indicated orders including, but not limited to, Miralax (stool softener/laxative) daily (originally dated 7/27/11), "Bivasc-evac 10 mg sup		issues were identified. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** · Licensed Nurses will audit medication/treatment records with on-coming shift to ensure medications are dispensed as prescribed and documentation is complete. · Nurse Manager's will audit 100% of medication/treatment records monthly x3 then quarterly x2 until 95% compliance is achieved.. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** · . Nurse Managers will audit 100% of medication/treatment records monthly x3 then quarterly x2 until 95% until compliance is achieved. · Data collected will reviewed by the CQI Committee. Those found to be non-compliant will receive re-education up to disciplinary action. If threshold of 95% is not achieved an action plan will be written. **What is the date by which the systemic changes will be completed?** March 16, 2012	

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	[suppository], insert 1 suppository rectally every other day [originally dated 2/22/10]," and Colace (stool softener) daily (originally dated 12/13/11). The resident also had orders for Milk of Magnesia (laxative) as needed for constipation (originally dated 12/31/07), and Fleets enema once daily as needed (originally dated 12/2/11). The Care Plan Update, dated 12/13/11, indicated a problem of constipation, with goal of "[symbol for no] constipation, and interventions of "Meds [medications] and lab as ordered." The Routine Medications record for February 2012 indicated the resident's medication was not administered as scheduled on 2/16/12 at 8:00 p.m.. The space for the nurse's initials to indicate administration was blank, and no information related to the omission was indicated. 3.1-37(a)			

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F0312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. Based on observation, interview, and record review, the facility failed to ensure residents received assistance to maintain personal hygiene for 2 of 3 residents reviewed related to showers and bathing in a sample of 4. (Residents B and D) Findings include: 1. On 2/27/12 at 9:35 a.m., Resident B was observed during a bed bath provided by CNAs #16 and #22. The bottom of the resident's feet were observed to have thick, gray lint clinging to them. The resident's lower legs and feet were not washed, and the resident's feet were observed to have lint on the bottom when the bath was completed and the resident was covered with his bed clothes. 2. Resident D's name was included on a list of interviewable residents provided by Assistant Director of Nursing during Initial Tour on 2/26/12 at 3:30 p.m. During interview completed on 2/28/12 at 11:15 a.m., Resident D indicated he was scheduled for showers on Monday,	F0312	**F312 ADL Care Provided For Dependent Residents.** This facility provides to residents who are unable to carry out activities of daily living the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** · Resident B is provided bed bath in accordance with the standard of practice. · Resident D receives his showers in the evenings per his request. Resident is offered a bed bath when he refuses a shower. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** · Residents who are dependent on staff for ADL care has the potential to be affected by the alleged deficient practice. · All residents are offered showers per resident's choice of time. Those who refuse showers are offered bed baths. · Licensed Nurse and Certified Nursing Assistants were re-educated related to offering a	03/16/2012

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	Wednesday, and Friday. The resident indicated he preferred his showers in the evening, but "it did not happen the week before last." He indicated he did not receive a bed bath as a substitute for the shower. The clinical record for Resident D was reviewed on 2/26/12 at 7:25 p.m. The resident's care plan, with Problem Start Date of 12/2/11, indicated the resident had a self-care deficit with activities of daily living (ADL) related to quadriplegia. CNA Assignment Sheet for Resident D was provided during the Initial Tour on 2/26/12 at 3:30 p.m. The assignment indicated the resident was scheduled for showers on Monday, Wednesday, and Friday on the evening shift. The resident's ADL Records for January 2012 indicated the following: Week of January 1: 1 shower, 1 bed bath; no refusals Week of January 8: no shower, 1 bed bath; no refusals Week of January 15: 1 shower, no bed bath; no refusals Week of January 22: 2 bed baths, 1 shower; no refusals		bed bath when a resident refuses shower by the DNS/Nurse Consultant on 03-08-12 Post test was completed. · Certified Nursing Assistants and Licensed Nurses were re-educated on the proper documentation for care on 3-8-2012. · Certified Nurses Aides were re educated on proper technique of Bed bath completed on 03-15-12 by DNS/SDC/Designee. · Certified Nurses Aides who performed the bath were one on one re educated with DNS/Designee on 03/15/12. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** · The ADL grids are reviewed daily in the morning clinical meeting for identified issues. · Executive Director/designee will attend the Resident Counsel Meeting monthly times three to identify care issues. · Process was put into place if resident refuses shower/ Supervisor is informed of refusal and is re approached by supervisor/and bed bath is offered. If resident refuses resident is asked to sign refusal on shower sheet. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** · Social Services will conduct	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	(The resident was hospitalized 1/28/12 through 1/31/12.) The resident's ADL Records for February 2012 indicated the following: Week of February 1: 2 showers; (One refusal on the same day/shift the shower was documented as given) Week of February 8: 1 bed bath; no refusals Week of February 15: no showers, 2 bed baths; 1 refusal Week of February 22 (through 2/28/12 first shift) : 1 shower, 2 bed baths; no refusals. This federal tag relates to Complaint IN00103856. 3.1-38(a)(3)(A)		interviews with 100% of the residents regarding compliance with showers monthly x3 then quarterly x2 until threshold of 95% is achieved. Data gathered will be reviewed by the CQI committee. If threshold of 95% is not achieved, an action may be developed. **What is the date by which the systemic changes will be completed?** March 16, 2012	

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	155148	A. BUILDING 00 B. WING	02/28/2012

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F0314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. Based on observation, record review, and interview, the facility failed to ensure residents with pressure ulcers were accurately assessed, the physician was notified, and treatments were provided to prevent new and recurring pressure ulcers for 2 of 3 residents reviewed related to wounds in a sample of 4. (Residents B and D) Findings include: 1. The clinical record for Resident D was reviewed on 2/26/12 at 7:25 p.m. The record indicated the resident was readmitted to the facility on 1/31/12 after being hospitalized on 1/28/12. Diagnoses included, but were not limited to, quadriplegia. The resident's care plan included, but was not limited to, "Problem start date 1/6/11, Resident is at risk for skin	F0314	**F314 Treatment/SVCS to Prevent/Heal Pressure Sores** This facility based on the comprehensive assessment of a resident ensures that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** · Resident D is receiving care and services per physician orders to promote wound healing. The wound is decreasing in size.	03/16/2012

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	breakdown...H/O [history of] pressure ulcers - has current pressure ulcer RESIDENT IS NONCOMPLIANT WITH LYING DOWN." The goal, with target date of 3/2/12, indicated the resident would have healing of the current ulcer and remain free of further skin breakdown. Approaches included, but were not limited to, encouraging the resident to adhere to the scheduled time up and change positions frequently in the wheel chair, with intervention start date of 12/2/11. Other interventions in place since 1/6/11 included, but were not limited to, "Treatment of pressure ulcer (right buttocks) as ordered - observe for s/s [signs and symptoms] of increasing size, wound changes with s/s infection - notify physician." No updated interventions had been added since 12/2/11. The resident's care plan also included, but was not limited to, "Problem start date: 10/31/11 Resident is resistive to care as evidenced by: Resident is non-compliant with wound care, he refuses to lay of his bottom [sic], he refuses to let the nures [sic] apply treatment. Interventions had not been revised since 10/31/11. The resident's care plan also included, but was not limited to, "Problem start date: 2/27/12 Resident has impaired skin		Resident's care is updated to reflect resident's non-compliance with care and treatment and impaired skin integrity. · Resident B is provided care and services to promote wound healing. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** · Residents who are at risk/or have pressure ulcers have the potential to be affected by the alleged deficient practice. · Licensed Nurses were re-educated by the DNS/designee on the wound program including documentation on 3-8-2012. · The Certified Nursing Assistants were re-educated on wound prevention and intervention i.e. pillows between knees, turning and repositioning, peri-care by DNS/Designee. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** · Residents are assessed for pressure risk upon admission, quarterly, and with significant change. · Preventative measures are put into place upon identification of a resident at risk. · The Interdisciplinary wound team rounds weekly to review	

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	integrity: rt [right] upper inner thigh." The only intervention included in the plan, which was not also included in the plan dated 1/6/11, was "Labs as ordered." A Nurse's Note, dated 1/25/12 at 7:00 a.m., indicated, "IDT [interdisciplinary team] wound rounds this AM [morning] appears as excoriation with two small open areas. Team recommends EPC [Extra Protective Cream] q [every] shift and prn [as needed]. Call to [name of attending physician] for orders. Triage. D/C [discontinue] previous orders." Documentation in the record failed to indicate measurements of the excoriated area or "two small open areas." During interview on 2/28/12 at 11:55 a.m. in regard to the measurements of the open areas, the Director of Nursing Services (DNS) indicated the facility would not have a "skin sheet" related to the wound, since it was "excoriation," but she indicated she would try to find documentation in a thinned record. During interview on 2/28/12 at 12:45 p.m., the DNS provided a "Wound Skin Evaluation Report" indicating "Date Wound Developed" was 12/6/11 on "R [right] inner thigh [arrow pointing up - upper]." The documentation indicated the		those residents with wounds and those at risk to ensure appropriate treatments and interventions are in place. · Licensed Nurses assess resident's weekly head-to-toe to identify any skin integrity issues. · Licensed Nurses will round per shift 7 days weekly to ensure compliance with resident plan of care. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** · A Wound CQI tool will be utilized weekly times four and monthly 3 then quarterly thereafter until compliance x2 by DNS/Designee. Data gathered will be reviewed by the CQI committee. If threshold of 95% is not achieved, an action may be developed. **What is the date by which the systemic changes will be completed?** March 16, 2012	

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	wound was excoriation of 0.5 by 0.5 cm length by width with no depth, no tunneling, red color, scant drainage, and no odor on 12/6/12. The documentation indicated the measurements decreased in size with no open areas until 1/18/12, when the size was 0.3 by 0.2 cm. The documentation for 1/25/12 indicated the wound was 0.1 by 0.1 cm with no depth, no tunneling, red color, no drainage. In the area for "Comments" was "Slightly open." No measurements of the two open areas mentioned in the Nurse's Notes were indicated. The Treatment Orders record for January 2012 included, but was not limited to, the following: An order for "EPC Cream to buttocks/perineum twice daily and as needed" had an original order date of 9/28/11. The entry indicated with a nurse's initials that the treatment was administered as follows: twice daily from January 1 through January 16, 2012; once daily from January 17 through January 27, 2012; not administered 1/28/12; and administered once daily on 1/29/12. (The resident was hospitalized on 1/29/12.) A circle was drawn around the dates of 1/30 and 1/31/12.			

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	An order for "Secura Protective Cream (EPC) Apply to right thigh - [no further information]" with original order date of 12/8/11. No nurse's initials were next to the entry. An order for "Secura Protective Cream (EPC) Apply cream to buttock/peri area twice daily and as needed for soilage," had an original order date of 8/19/11. A nurse's initials next to the entry indicated the treatment was administered twice daily from January 1 through January 26, and not administered on 1/27/12. An order dated 1/25/12 for "EPC Cream to ischial Rt [right] q [every] shift & prn [as needed] soilage to excoriated area until resolves." Nurse's initials next to the entry indicated the treatment was administered three times daily January 25 through 26, 2012, and two times on January 27, 2012. Nurse's notes indicated the resident was discharged to the hospital on 1/28/12 and returned on 1/31/12. The American Senior Communities Nursing Admission Assessment, dated 1/31/12, indicated the resident had a "pressure area R [right] ischial" with measurement of 4.2 X 2.2 cm.			

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	During interview on 2/28/12 at 2:15 p.m. in regard to further description of this wound, the DNS indicated she would look in "overflow" records to see what she could find. A Pressure Wound Skin Evaluation was located and provided by the DNS and indicated, "Date Wound Developed: Admit." This document had entries describing the wound, one on 1/31/12, and one on 2/8/12. The first wound information entry, dated 1/31/12, indicated the wound was a Stage 2, 4.2 cm by 2.2 cm with no depth, no tunneling, tissue type of granulating, "rubra" drainage, and slight odor. Interdisciplinary Progress Notes for 2/2/12 indicated, "IDT wound rounds this a.m. [morning] visualized R [right] ischial et [and] observed excoriation...." The note did not indicate a plan related to the wound care. The Treatment Orders for February 2012 indicated, "Secura Protective Cream (EPC), apply to excoriated area of right ischial every shift and as needed for soilage until resolved," with an original order date of 1/25/12. Nurse's initials next to the entry indicated the treatment was administered three times per day as ordered, except for the following dates			

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	when the treatment was administered twice: 2/5, 2/6, 2/13, 2/14, 2/15, 2/17, 2/19, 2/21, and 2/23/12. Initials indicated the treatment was administered one time on 2/22/12, and no times on 2/24/12. Nurse's notes for 2/3/12 at 11:40 a.m., indicated, "...Also requested secondary tx [treatment] to area on R [right] ischial [symbol for with] [arrow pointing up - increased] redness...." Physician Telephone Orders, dated 2/3/12, included, but were not limited to, "Neosporin BID [twice daily] X 10 days then call [symbol for with] update." Treatment Orders record for February 2012 indicated the Neosporin treatment was administered twice daily except 2/8/12, when it was administered only one time. The Pressure Wound Skin Evaluation entry, dated 2/8/12, indicated the right ischial wound was a Stage 2, 4 cm by 2 cm with no depth and no tunneling. Information related to tissue type, drainage, and odor were blank. Handwritten across the form was "Area [symbol of changed] 2/13/12 See new sheet." Nurse's notes on 2/13/12 at 11:30 p.m.,			

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	indicated, "Resident up in W/C [wheel chair] this shift, refused to lie down in bed to relieve pressure to buttocks, back to bed at 21:30 [9:30 p.m.], skin assessment completed, noted change to R ischial, measurements taken, placed on pressure area assessment skin sheet, noted moderate amount bloody drainage, no odor, refused to lie on left side [symbol for after] being placed in bed, [illegible word] non-compliant [symbol for with] repositioning, understands effects." Documentation failed to indicate the change in the wound was reported to the physician. The Pressure Wound Skin Evaluation, mentioned in the Nurse's Notes as started on 2/13/12, indicated the wound was present on admission, with "Date Wound Developed: Admit of 1/31/12." Handwritten next to this was: "Area was excoriation previous hospital." The first wound information entry, dated 2/13/12, indicated the wound was Stage 2, 3.9 cm by 3 cm with less than 0.1 cm depth, no tunneling, granulating tissue, moderate bloody drainage, and no odor. "Comments" indicated, "Area [symbol for changed], small areas now one area, Tx [treatment] given as ordered." A Nurse's Note, dated 2/17/12 at 10:00			

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	p.m., indicated, "...existing wound on upper R thigh was noted to be oozing blood, so the phone nurse for [name of attending physician] reinstated the old order for Allevyn gentle 4 X 4 apply to open area after cleaning with normal saline. Change every 3 days or prn for dislodgement. Will continue to monitor." Treatment Orders record for February 2012 indicated the order was transcribed onto the record. No entries indicated dates the treatment was planned to be administered. No entries indicated the treatment was administered. The Pressure Wound Skin Evaluation entry for 2/20/12 indicated the wound was a Stage 2, 3.5 cm X 2.8 cm X less than 0.2 cm with no tunneling, and granulation tissue. The column for documenting drainage was blank. "Comments" indicated, "Improving." An entry for 2/24/12 indicated the wound was Stage 2, 3.3 X 2.7 X less than 0.2, no tunneling, granulation tissue, no drainage, and no odor. "Comments" indicated, "Therapy mist." The entries for 2/20 and 2/24/12 were signed by nursing staff. On 2/27/12 at 8:35 a.m., the DNS was observed at the nurse's station on Resident D's hall. During interview at this time, the DNS indicated the resident would be			

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	receiving mist therapy to his wound this morning. She indicated the facility was having good success with the treatment. She indicated the resident was non-compliant with care and pressure relief to the area on the right ischial, which had healed and re-opened numerous times. She indicated when the resident went to the hospital on 1/28/12, the wound was just excoriation but after the hospitalization was a Stage 2 pressure ulcer. On 2/27/12 at 9:00 a.m., the DNS indicated the resident was ready for the mist therapy to his wound. Upon entrance to the resident's room, the treatment was in process. The resident was observed to have an open, moist, beefy red wound to the right ischial area. PTA [Physical Therapist Assistant] #3 was at the bedside providing the treatment. PTA #3 described the treatment as ultrasound to a wound using a mist of normal saline, which made the ultrasound more effective in reaching the wound bed and maintaining wound moisture. The DNS was at the bedside and asked PTA #3 the date on the wound dressing that she had removed. PTA #3 indicated she did not notice the date and had discarded the dressing. Nurse's notes for 2/27/12 at 2:25 p.m.,			

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	indicated, "Pt [patient] to recv [receive] PT [physical therapy] 3/wk [three times a week] for wound care inclusive of mist therapy to R LE [lower extremity] [sic] to promote healing...." Nurse's notes for 2/27/12 at 3:10 p.m., indicated," Call triage for tx. [treatment]. Tx denied at this time. Wants recommendation from wound team. ADON [Assistant Director of Nursing] notified. Therapy Observation Reports for assessment of the resident's wound indicated the following: Two Therapy Assessment reports with "Observation Date: 2/24/12" and "Date Recorded: 2/28/12" indicated "Reason for referral: resident presents with 2 wounds at posterior thigh/buttocks with narrow separation." The first report indicated the first wound was "right posterior thigh/buttocks - upper and lateral region." The wound was Stage 2 with suspected origin of pressure and shearing. The length, by width, by depth, using a clock method was 3.3 cm X 2.7 cm X 0.2 cm with scant exudate and no odor. The second report indicated the second			

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	wound was a right posterior thigh/buttocks wound at lower medial region. The wound was Stage 2 with suspected origin of pressure and shearing. The length, by width, by depth, using a clock method, was 5.2 cm X 3.1 cm X 0.2 cm with scant exudate and no odor. During interview on 2/28/12 at 2:05 p.m., the Director of Rehab Services indicated Resident D started the mist therapy to his wound on 2/27/12. Resident D was listed as interviewable on a list provided by the Assistant Director of Nursing on the Initial Tour on 2/26/12 at 3:30 p.m. During interview completed on 2/28/12 at 11:15 a.m., Resident D indicated staff does not assist him routinely to reposition in bed. He indicated staff sometimes is not careful when assisting him to don pants to ensure the pants are not scraped across the wound to his buttocks. The resident also indicated the straps to the Hoyer lift sometimes scrape across the buttock wound. On 2/28/12 at 11:45 a.m., the DNS provided a second copy of Resident D's Treatment Orders record for February 2012. Review of the documentation indicated the following next to the entry			

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	for "Allevyn gentle 4 X 4 apply to open area after cleaning with normal saline. Change every 3 days or prn for dislodgement:" A box was now drawn around the following dates: 2/17, 2/20, 2/23, and 2/26/12. A nurse's initial was now indicated in each of the boxes. At this time the DNS also provided copy of a Pressure Wound Skin Evaluation Report and indicated it showed documentation of a second wound to the resident's right ischial area. She indicated as of 2/27/12, the two wounds had merged into one wound. The Report indicated the wound was not present on admission and developed on 2/24/12. The location of the wound indicated, "Right ischial [arrow pointing down]." An entry dated 2/24/12, indicated the wound was a Stage 2, with length of 5.2 cm, width of 3.1 cm, and depth of 0.2 cm. The documentation indicated no tunneling, tissue type "red," slight drainage, and no odor. In the "Comments" section was "PT [Physical Therapy]/Nursing." The documentation was signed with the initials of the Physical Therapist who completed the Therapy Observation Reports, dated 2/24/12, related to the resident's two wounds to the right ischium. During interview on 2/28/12 at 2:15 p.m.			

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	in regard to the revised Treatment Order record, the DNS indicated she had drawn boxes around the dates when the treatment should be been administered. She indicated while she and the Corporate Nurse Consultant were talking to the nurse responsible for the dressing changes about the lack of documentation, the nurse filled in her initials. During interview on 2/28/12 at 2:45 p.m., LPN #4 indicated she was sure she had done the dressing changes for Resident D, so she filled in her initials During interview at this same time, the DNS indicated the nurse "thought it was what I wanted her to do, since I had drawn the boxes" around the appropriate dates on the Treatment Orders form. During interview on 2/28/12 at 3:05 p.m., the facility's Corporate Nurse Consultant indicated she had recently inserviced the Interdisciplinary Team and nursing staff about wounds. The Consultant provided copies of inservice records. Review of the documentation at this time indicated an outline for "Identification and Prevention of Wounds Outline...What does the nurse do when we have a skin issue: 1. Assessment!!!!! 2. Notify physician and family 3. Appropriate treatment 4. Reduce pressure. What does the nurse do to promote wound healing?			

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	155148	A. BUILDING 00 B. WING	02/28/2012

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	1. Do the treatment!!!! and Document!!!!! 2. Monitor the area to reduce pressure using bolsters, pillows, turn and repositioning...." The Consultant indicated LPN #4 attended the inservice. 2. The clinical record for Resident B was reviewed on 2/26/12 at 5:50 p.m. Diagnoses included, but were not limited to, paraplegia and brain injury. Pressure Wound Skin Evaluation Report, most recently dated 2/24/12, indicated the resident had a Stage 3 pressure ulcer to the coccyx. The care plan, with "Problem Start Date" of 3/30/11, indicated, "Resident is at risk for skin breakdown r/t [related to] paraplegia." The goal, with Goal Target Date of 4/6/12 indicated, "Resident will be free from further skin breakdown." Approaches, most recently dated 3/30/1, included, but were not limited to, "Preventative treatment as needed." The CNA Assignment Sheet for Resident B was provided during the Initial Tour on 2/26/12 at 3:30 p.m. The "Special Needs" section for Resident B included, but was not limited to, "...Dress in long pants at all times and place pillow between legs in bed...."			

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	Nurse's notes, dated 12/20/11 at 10:30 a.m. and 12/21/11 at 9:00 p.m., indicated the resident was non-compliant with keeping a pillow between his legs. Physician's rewrite orders for February 2012 included, but were not limited to, orders for treatments to the Stage 3 coccyx wound and skin prep to wounds to the right anterior shin, right knee, and left heel. The wounds to the lower extremities were documented as non-pressure wounds. On 2/27/12 at 9:35 a.m., Resident B was observed during a bed bath provided by CNAs #16 and #22. The resident was in bed turned slightly to the right. When the bed clothes were removed from Resident B's legs, the legs were positioned to the right, one on top of the other. The legs were unclothed and had no padding between. A dressing was observed to the right shin, and two red marks were observed on the left shin. On the right knee was a round indented scar which was red in the center. When the bed bath was complete, the resident was dressed in a hospital style gown and no pants were provided. No pillow or padding was placed between the resident's legs. During interview when the CNAs left the room after the bed bath, Resident B			

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	indicated he would be willing to try a pillow between his legs to prevent pressure. During interview on 2/28/12 at 3:20 p.m., LPN #15 indicated she was not Resident B's nurse but could probably give information about him. When interviewed to learn if the resident had a pillow between his legs, she indicated she didn't know, but she thought he probably would not allow a pillow between his legs. CNA #24 assisted with an observation of Resident B in bed at this time. The resident's lower legs were bare and lying one on top of the other, and no pillow or padding was between the legs. When asked, the resident indicated he was willing for a pillow to be placed between the legs. CNA #24 indicated no spare pillow was in the room, and she went to the linen closet. She indicated no pillow was in the closet. Laundry/housekeeper #12 was passing by and indicated he would obtain a pillow from laundry, and two pillows were provided. CNA #24 placed the pillow between the resident's legs, and replaced the resident's bed covers. This federal tag relates to Complaint IN00103856 and Complaint IN00104314. 3.1-40(a)(1)			

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	3.1-40(a)(2) 3.1-40(a)(3)			

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F0315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. Based on observation, interview, and record review, the facility failed to ensure staff handled the catheter bag and tubing with practices to help prevent urinary tract infections. (Residents C) The facility also failed to implement the physician's order related to a urology consult. (Resident D) The deficient practice affected 2 of 3 residents reviewed related to indwelling urinary catheters in a sample of 4. (Residents C and D) Findings include: 1. On 2/26/12 at 4:10 p.m., Resident C's wound dressing was observed with LPN #17. CNA #7 was at the bedside with Resident C's wheel chair, and during interview at this time, CNA #7 indicated she was preparing to assist the resident to the dining room for supper. The resident's catheter bag containing dark	F0315	**F315 No Catheter, Prevent UTI, Restore Bladder** This facility based on the resident's comprehensive assessment ensures that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. **What corrective action(s) will be?** **accomplished for those residents found to have been affected by the deficient practice?** · Resident C catheter is maintained using infection control.	03/16/2012

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	yellow urine was observed lying folded over on the floor. LPN #17 did not remove the bag from the floor, and she did not instruct CNA #7 to remove the bag from the floor. On 2/26/12 at 4:20 p.m., Resident C was observed in his wheel chair using his feet to propel himself toward the dining room. The resident's catheter bag was in a dignity bag under the wheel chair, and the bag dragged along the floor. The catheter tubing was observed to drag along the floor, and the resident was observed to step on the tubing with his shoe as he propelled himself along. On 2/27/12 at 11:30 a.m., Resident C was observed seated at a table in the dining room. The resident's catheter tubing was observed on the floor under the wheel chair. The clinical record for Resident C was reviewed on 2/26/12 at 4:35 p.m. The record indicated the resident had a supra pubic catheter. The resident's care plan, with "Problem Start Date: 4/8/11" indicated, "Problem: Resident has chronic urinary tract infections." The goal, with Goal Target Date of 4/20/12, indicated, "Resident will be free of signs/symptoms of urinary tract		· Resident D saw the Urologist On 03-09-12 with no new orders received. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** · Residents with urinary catheters have the potential to be affected by the alleged deficient practice. · Audit was completed of all urinary catheters on 03-08-12 with no other issues found. · Licensed Nurses and Certified Nursing Assistants have been re-educated on catheter care as to maintain infection control by the DNS/Nurse Consultant on 3-8-2012. · Licensed Nurses were re-educated on proper follow up on physician orders by DNS/designee on 3-8-2012. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** · Licensed Nurses will round every shift to ensure compliance with infection control. · Nurse Managers will round daily shift to ensure Foley catheters are being maintained appropriately. · Nurse Managers will place needed follow up on the	

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	infections (UTI)." A physician's order, dated 2/20/12, indicated urinalysis with culture and sensitivity. Nurse's notes, dated 2/25/12 at 4:00 p.m., indicated, "Received N/Os [new orders] D/T [due to] lab (UTI) results." The Routine Medications record indicated the resident was started on the antibiotic, Bactrim, for ten days. 2. The clinical record for Resident D was reviewed on 2/26/12 at 7:25 p.m. The record indicated the resident had diagnoses including, but not limited to, quadriplegia, neurogenic bladder, and urosepsis. The record indicated the resident had a supra pubic urinary catheter. The resident's care plan, with "Problem Start Date: 12/2/11" indicated, "Resident has hx [history of] chronic urinary tract infection, urosepsis 9/20/11 - neurogenic bladder 9/20/11." A physician's order, dated 12/13/11 indicated, "UA C&S [urinalysis with culture and sensitivity]. Pt [patient] C/O [complains of] pain in bladder area. If UA neg [negative] send to [name of		Continuous Quality Improvement minutes to ensure appropriate follow up has been completed. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place** ·Check list Nurse rounds is being completed every shift to ensure catheter compliance. · Data will be reviewed by the CQI committee and if threshold of 95% is not achieved an action plan may be developed. **What Date can the systemic changes be completed?** March 16, 2012	

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	resident's urologist]." A physician's order was received 12/15/12 for Bactrim DS [antibiotic] 1 by mouth twice daily for seven days and Bacid [probiotic], 2 by mouth twice daily for 21 days. Notation on the lab results of the culture and sensitivity following urinalysis on 12/14/11, indicated the physician was notified of the results of the culture and sensitivity on 12/17/11, which indicated, Escherichia coli ESBL, greater than 100,000 colony forming units, and "Confirmed ESBL producing organism....Recommend caution and monitoring of patients during/after therapy." Also cultured with no sensitivity done were mixed skin flora of greater than 100,000 colony forming units. Nurse's notes, dated 12/18/11 at 1:00 p.m., indicated the physician ordered a new antibiotic, and the medication record indicated, "Cipro 500 mg p.o. [by mouth] BID [twice daily] X 10 days." Nurse's notes, dated 12/18/11 at 5:30 p.m., indicated the pharmacy called to say the resident was allergic to Cipro. Notes indicated the physician's triage was notified of the allergy.			

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	During Daily Exit on 2/27/12 at 3:00 p.m. the Director of Nursing Services (DNS) and Nurse Consultant were interviewed in regard to clarification as to what antibiotic was administered when pharmacy indicated the resident was allergic to Cipro. The Director of Nursing Services indicated she would locate the information. On 2/28/12 at 10:25 a.m., the Nurse Consultant provided copy of a Physician Telephone Order, dated 12/18/11 at 7:30 p.m., indicating to discontinue Cipro, discontinue prophylactic antibiotics (Bactrim) , and discontinue Baccid. The Physician Telephone Order also indicated in the Care Plan Update section in the column for "Problem: does not warrant ATB [antibiotic] @ this X [time] AEB [as evidenced by] [symbol for negative] UTI." Documentation failed to indicate the resident was scheduled for an appointment with the urologist as indicated, if the resident did not have urinary tract infection, as ordered by the physician on the order of 12/13/11. During interview on 2/28/12 at 2:55 p.m., the Director of Health Services indicated an appointment was not scheduled with			

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	the urologist. She indicated the resident last saw his urologist in January 2011. Copy of a hospital Admission History and Physical, dated 1/29/12, indicated, "...presented to the ER [Emergency Room] from his NH [nursing home] for evaluation of a fever of 104.1 which was associated with hypotension in the ER. Workup in ER point toward urosepsis and patient was admitted to ICU [intensive care unit] with that diagnosis." This federal tag relates to Complaint IN00103856. 3.1-41(a)(2)			

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F0465 SS=B	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. Based on observation and interview, the facility failed to ensure the nurse's station on the Faith Meadows unit was clean. The deficient practice had the potential to affect 27 of 92 residents residing in the facility. Findings include: During observation in the Nurse's Station on Faith Meadows unit 2/26/12 at 5:40 p.m., the floor was gritty underfoot. The floor was soiled with gray scuffs. The chart rack in the stations was observed to have dust and gritty dirt on the bottom shelf where charts were placed. During interview on 2/28/12 at 11:15 a.m., the Director of Nursing Services (DNS) indicated the facility plans to move the Nurse's Station on Faith Meadows across the hallway so both hallways next to the Station would be visible. She indicated the floor buffer would not fit into the Nurse's Station, and then she asked a Housekeeper in the hallway to try moving the chart rack to see if the buffer could come into the Nurse's Station to clean the floor.	F0465	**F465 SAFE/FUNCTIONAL/ COMFORTABLE ENVIRONMENT** **The facility provides a safe, functional, sanitary and comfortable environment for residents, staff and the public.** **What corrective action(s) will be?** **accomplished for those residents found to have been affected by the deficient practice?** No residents were identified in the alleged deficient practice, **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** ·No residents were identified in the alleged deficient practice. ·All chart racks have been cleaned per housekeeping supervisor/designee complete 03/16/12. ·Nurses station flooring approved for replacement on 03-1512.	03/16/2012

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	During interview on 2/28/12 at 11:55 a.m., the DNS provided paperwork she indicated was related to the facility's flooring. During interview at this same time, the Administrator indicated the replacement of the flooring in the Faith Meadows Nurse's Station was scheduled this year. Review of the paperwork provided indicated "Health and Hospital Corporation 2012 Capital Budget Request North Park Nursing Center." No signatures on the documentation indicated approval or dates of approval of the installation of new flooring. Circled in highlighter were: typed messages: "New Nurses Station and Med Room - Station II," "Reno - F and Front Hall Flooring," and handwritten message: "use flooring from previous referb [refurbishing] DR [dining room] - kitchen small hallway." During Initial Tour on 2/26/12 at 3:30 p.m., the Assistant Director of Nursing provided a list of residents in the facility. Review of the list indicated 26 residents lived on Faith Meadows unit. This federal tag relates to Complaint IN00103856. 3.1-19(f)		**What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** · Housekeeping Supervisor/designee will monitor through daily rounds to ensure chart racks are cleaned. · Housekeeping supervisor/designee will report monthly results of daily rounds to CQI committee. · Maintenance Supervisor/Designee will monitor the remodeling of Nurses station/flooring and report progress to CQI committee monthly. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** Data collected will be reviewed by the CQI Committee. If threshold of 95% is not achieved, an action plan will be developed. **What is the date by which the systemic changes will be completed?** March 16, 2012	

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F0514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.			
	Based on record review and interview, the facility failed to ensure documentation was accurate in the clinical record for 1 of 3 residents whose records were reviewed related to accurate documentation in a sample of 4. (Resident D) Findings include: The clinical record for Resident D was reviewed on 2/26/12 at 7:25 p.m. The record indicated the resident was readmitted to the facility on 1/31/12 after being hospitalized on 1/28/12. Diagnoses included, but were not limited to, quadriplegia. A Nurse's Note, dated 2/17/12 at 10:00 p.m., indicated, "...existing wound on upper R thigh was noted to be oozing blood, so the phone nurse for [name of	F0514	**F514** **Records-complete/accurate/accessible** This facility maintains clinical records on each resident in accordance with accepted professional standards and practices that are complete accurately documented; readily accessible; and systematically organized. **What corrective action(s) will be?** **accomplished for those residents found to have been affected by the deficient practice?** · Resident D medication and treatment records are documented as per physician orders. **How will you identify other**	03/16/2012

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	attending physician] reinstated the old order for Allevyn gentle 4 X 4 apply to open area after cleaning with normal saline. Change every 3 days or prn for dislodgement. Will continue to monitor." Treatment Orders record for February 2012 indicated the order was transcribed onto the record. No entries indicated dates the treatment was planned to be administered. No entries indicated the treatment was administered. On 2/28/12 at 11:45 a.m., the DNS provided a copy of the Resident D's Treatment Orders record for February 2012. Review of the documentation indicated the following next to the entry for "Allevyn gentle 4 X 4 apply to open area after cleaning with normal saline. Change every 3 days or prn for dislodgement:" A box was drawn around the following dates: 2/17, 2/20, 2/23, and 2/26/12. A nurse's initial was indicated in each of the boxes. During interview on 2/28/12 at 2:15 p.m. in regard to the revised Treatment Order record, the DNS indicated she had drawn boxes around the dates when the treatment should be been administered. She indicated while she and the Corporate Nurse Consultant were talking to the nurse responsible for the dressing changes		**residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** · Residents who have medication/treatments administered have the potential to be affected by the alleged deficient practice. · Licensed Nurses were re-educated related to medication/treatment documentation by the DNS/designee on 3-8-2012. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** · Nurse Manager's will observe one nurse weekly during a medication/treatment administration for medication/treatment documentation. · The on-coming nurse will review the MAR/TAR for completeness while giving report. · Nurse Managers will audit the MAR/TAR weekly x 4 then monthly x3 for compliance. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155148	A. BUILDING 00 B. WING	02/28/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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	about the lack of documentation, the nurse filled in her initials. During interview at this time, the Corporate Nurse Consultant and DNS indicated they did not think the facility had a policy related to late entries on the Treatment Record. Both indicated they would expect documentation entered after the fact to have indication it was a late entry. The Corporate Nurse Consultant indicated she would expect the nurse to enter the late entries within 48 hours. During interview on 2/28/12 at 2:45 p.m., LPN #4 indicated she was sure she had done the dressing changes for Resident D, so she filled in her initials During interview at this same time, the DNS indicated the nurse "thought it was what I wanted her to do, since I had drawn the boxes" around the appropriate dates on the Treatment Orders form. Resident D was indicated as an interviewable resident on the list provided by the Assistant Director of Nursing on Initial Tour on 2/26/12 at 3:30 p.m. During interview completed on 2/28/12 at 11:15 a.m., Resident D indicated a problem with care he encountered was related to his bowel regimen. Resident D indicated he was supposed to receive a suppository to assist with bowel		·A MAR/TAR audit will be completed weekly times four and monthly x3 quarterly thereafter until compliance x2 by DNS/Designee. Data collected will be reviewed by the CQI Committee. If threshold of 95% is not achieved, an action plan will be developed. **What is the date by which the systemic changes will be completed?** March 16, 2012	

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	movements every other day - Monday, Wednesday, Friday, then Sunday, Tuesday, Thursday, Saturday. Resident D indicated some nurses always gave the suppository on the days ordered, and others didn't. Resident D indicated the record always showed the nurses gave the suppository, when he knew they did not do so. This federal tag relates to Complaint IN00103856 and Complaint IN00104314. 3.1-50(a)(2)			